**CC 14 through 19**

**Practice Name**

**Address**

**City, State Zip**

**Phone**

# 10. Process: Care Transitions to/from Hospital and ED

**Purpose: To establish a process for coordinating patient care during and after transitions to acute care settings**

## A. Hospital Admissions

<Define & describe admission process used and staff responsible (multiple processes may apply)>

**CC 14**

1. Hospital admission process - <direct, hospitalist, scheduled, unplanned, through ED, etc.>
2. Standard documentation provided to hospital for admission <summaries, referrals, notes, reason, special requests, admit orders, shared EHR, etc.>

**CC 15**

1. Method of providing documentation to hospital <direct electronic interface, through HIE, fax, patient carries materials, phone calls to hospitalist, shared EHR, etc.>
2. Method of noting admissions in the practice EHR or chart <ability to obtain list of admitted patients from EHR or hospitals (see below)>

## B. Hospital Stay

<Define & describe communication process used, staff responsible (multiple processes may apply)>

**CC 14**

1. Agreements with hospitals to obtain daily Census lists <frequency & method of receipt>
2. Information received <calls with attending and/or consulting specialists, status updates, consult notes, hospital rounds, in-hospital consultations, etc.>

**CC 18**

1. Information sent <notes, test results, meds, allergies, all consultation models mentioned above>
2. Information exchange <electronic, fax, HIE, phone, in-person consults, patient/family, etc.>

**CC 17**

1. After-hours information exchange <on-call provider, 24/7 access to EHR, phone calls, etc.>

## C. Hospital Discharge

<Define & describe discharge process used and staff responsible (multiple processes may apply)>

**CC 14**

1. Notification of discharge from hospital
	1. Discharge list from hospital (or plans) <push by hospital/plans, pull by practice, combination, etc.>
	2. Content <discharge summary, interim letter, other>

**CC 19**

* 1. Method <direct electronic push, HIE push, faxed push, pull by the practice, access to hospital system, shared EHR, payer portals, sent with patient, other>
	2. Added to patient record <scanned in, electronically attached, etc.>
	3. Time frame < received within XX days from discharge>
1. Actions taken <patient call, call with hospitalist, contact consulting specialist(s), contact with discharge/case manager, scheduled follow up, house call, other>

**CC 16**

1. Time frame for follow up <XX days within 30 days period after discharge>

## D. ED Visits

<Define & describe communication process used and staff responsible (multiple processes may apply)>

1. Agreements with ED to <contact PCP, provide daily lists>

**CC 14**

1. Information received <calls with ER physician and/or consulting specialists, status updates, ED summary notes. etc.>
2. Information sent <notes, test results, meds, allergies, phone consultation>

**CC 18**

1. Information exchange <electronic, fax, HIE, phone, in-person consults, etc.>

## E. ED Discharge

<Define & describe discharge process used and staff responsible (multiple processes may apply)>

**CC 14**

1. Notification of discharge from ED
	1. Discharge list from ED (or plans) <push by hospital/plans, pull by practice, combination, etc.>
	2. Content <discharge summary, interim letter, other>

**CC 19**

* 1. Method <direct electronic push, HIE push, faxed push, pull by the practice, access to hospital system, shared EHR, payer portals, sent with patient, other>
	2. Added to patient record <scanned in, electronically attached, etc.>
	3. Time frame < received within XX days from visit>
1. Actions taken <patient call, call with ED, contact consulting specialist(s), contact with discharge/case manager, scheduled follow up, house call, other>

**CC 16**

1. Time frame for follow up <XX days after discharge>

**Approved By:**

**Effective:** 6/15/2017

**Revised:**